CountyCare Compliance Program

Annual Report
Fiscal Year 2018
December 1, 2017 – November 30, 2018

February 28, 2019

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I. Introduction

CountyCare is a Managed Care Community Network (MCCN) health plan offered by Cook County Health (CCH) pursuant to a contract with the Illinois Department of Healthcare and Family Services (HFS). Since late 2012, CCH has partnered with the State of Illinois, initially through the State of Illinois federal Section 1115 demonstration waiver which was an early start on Medicaid expansion, then in 2014, CountyCare transitioned into the MCCN. By working to employ the advantages of our parent organization, CCH, CountyCare is able to uniquely promote achievement of the Triple Aim: 1) improving the member experience, 2) improving the health of populations overall, while 3) reducing the cost of care. The operation of the CountyCare MCCN is facilitated through CCH and its various subcontractors.

To adhere to the Centers for Medicare & Medicaid Services (CMS) Managed Care Program Integrity requirements[1], contractual provisions in the MCCN Agreement with HFS, and the elements of an effective compliance program as recommended in the Department of Health and Human Services Office of Inspector General (OIG) Compliance Program Guidance publications, CountyCare developed and implemented the CountyCare Compliance Program. The CountyCare Compliance Program is designed to demonstrate the health plan's ongoing commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCH policies, procedures, and Code of Ethics/Standards of Conduct.

This Annual Report presents the activities throughout county fiscal year 2018. The CountyCare Managed Care Compliance Program is under the executive leadership of Cathy Bodnar, Chief Compliance and Privacy Officer, and the operational leadership of Elizabeth Festa, CCH Compliance Officer dedicated to CountyCare.

During this past fiscal year, CountyCare Health Plan, as a whole, accomplished many goals and implemented a variety of initiatives. A few health plan achievements include:

- CountyCare Became the Largest Medicaid Health Plan in Cook County: In FY2018, CountyCare acquired the Medicaid membership of both Aetna and Family Health Network (FHN), becoming the largest Medicaid Health Plan in Cook County.
- Medicaid Redetermination Efforts: CountyCare sought to retain membership by helping members with their Medicaid redetermination process. Triggers were developed for providers, prompts were embedded within providers' health information systems, and redetermination events throughout the county were held to help members maintain their Medicaid eligibility and CountyCare membership.
- CMS Review of Illinois Medicaid Program Integrity Activity: CMS conducted a focused review of Illinois Medicaid to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by a random selection of the state's managed care organizations. CountyCare

[1] See 42 C.F.R. §438.608.

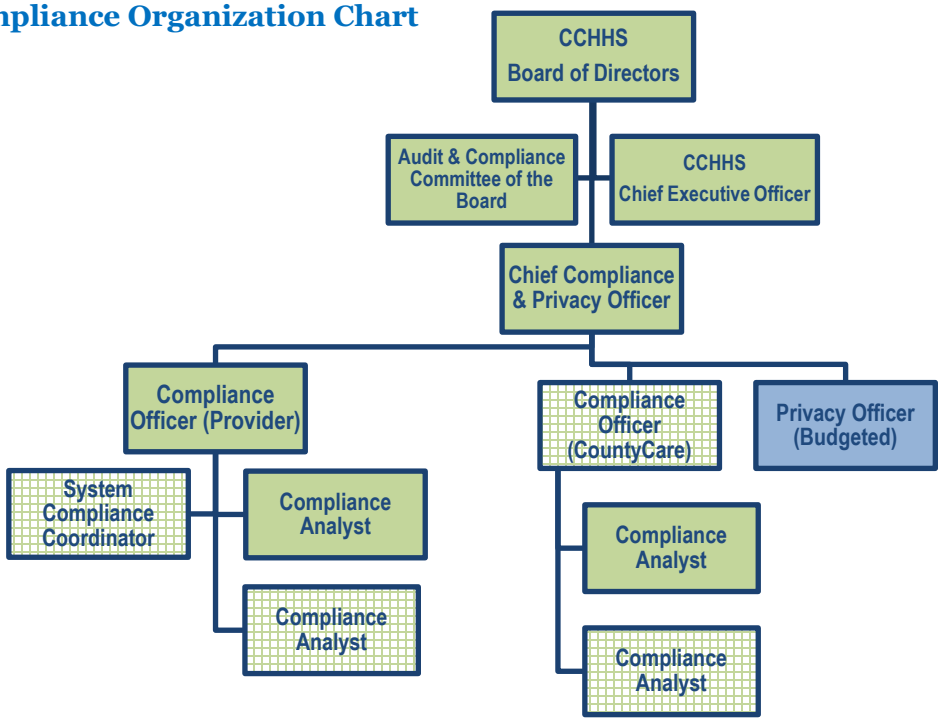
was selected, supplied numerous documents to support program integrity efforts, and Corporate Compliance travelled to Springfield to participate in interviews with CMS and HFS, strengthening its relationship with both entities and providing valuable insight into the Program Integrity activities of CountyCare.

The Corporate Compliance Program dedicated to CountyCare was directly involved in each major initiative to assure the execution adhered to and incorporated relevant regulatory directives and contractual requirements.

II. Building Blocks – Program Infrastructure and Scope

The Annual Report begins with a look at the structure and activities of the Program that incorporate efforts to foster an infrastructure that produces a comprehensive compliance program for CountyCare and its affiliates. The existing Departmental Organization Chart follows:

Compliance Organization Chart



The lightly shaded positions indicate the new hires within FY18. Two (2) of the 3-dedicated CountyCare Compliance Program positions were vacant for several months within the fiscal year, including the Compliance Officer assigned to CountyCare. This placed a significant strain on the existing resources. In the interim, Cathy Bodnar, functioned in an operational leadership capacity with significant, noteworthy support from Cory Otto, Compliance Analyst. Management of the core elements of the Program continued which was critical to the ongoing success of the CountyCare Compliance Program.

CountyCare Compliance Program Scope

The CountyCare Compliance Program is tasked with outlining guidelines and providing insight to:

- Comply with the CMS Managed Care Program Integrity requirements and the terms of the CountyCare Health Plan contract with HFS;
- Prevent, detect and eliminate fraud, waste, abuse, and financial misconduct;
- Protect health plan members, providers, CCH, the State, and the taxpaying public from potential fraudulent activities;
- Respond and provide guidance related to privacy, confidentiality, and security matters;
- Provide high level oversight to the health plan's Grievances and Appeals Program; and
- Understand and focus on high-risk areas that have the greatest potential for non-compliance with federal and state regulatory and contractual requirements.

Further, the program aims to implement a working communication strategy to increase the CountyCare workforce awareness, including vendors and subcontractors, of the following topics:

- Code of Ethics;
- Privacy, Confidentiality, and Security;
- Accessibility of the Compliance Officer and the compliance team;
- Availability through multiple modalities;
- Responsibility to report potential/actual issues;
- Consequences of not reporting; and
- Non-retaliation.

The following types of activities fall into the CountyCare Compliance Program purview:

- Interpretation of contracts, laws, rules, regulations, and organizational policy as they relate to CountyCare Compliance
- Accurate Books and Records
- Anti-kickback Activities
- Conflict of Interest
- False Claims
- Financial Integrity
- Fraud, Waste and Abuse
- Member Privacy, Confidentiality, and Security (HIPAA)

The CountyCare Compliance Program scope of work is subject to ongoing review and revision as deemed necessary to ensure ongoing compliance. It is designed to accommodate future changes in regulations and laws and may be updated to address activities not currently covered, issues related to new service offerings, or regulatory requirements.

III. Compliance Program Structure – Performance of the Elements

This section of the report serves to demonstrate the effectiveness and provide an assessment of program operations using the seven (7) Compliance Program Elements of a comprehensive compliance program, as outlined in the CMS Managed Care Program Integrity requirements[2] and by contractual provisions in the MCCN Agreement.

Element 1

The distribution of written Code of Ethics, as well as written policies and procedures that promote the health plan's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, waste and abuse. The CCH Code of Ethics applies to all CountyCare personnel, providers, agents and subcontractors. The Code of Ethics, as well as CCH's policies and procedures, support CountyCare's commitment to comply with all federal and state standards, including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements.

A. Policies and Procedures.

Compliance staff engaged in the following activities to promote and establish an effective compliance program for the CountyCare Health Plan:

1. Incorporated new and revised 2018 MCCN contractual language into vendor contracts and Requests for Proposals.
2. Continued to follow the CountyCare Compliance Plan that focuses exclusively on outlining the compliance responsibilities of the health plan and program design for implementation, as well as specific CountyCare compliance policies for high risk areas focused on health plan operations.
3. Ensured that CountyCare personnel, providers, agents and subcontractors had access to compliance documentation electronically and were provided with hard copies of compliance policies and procedures upon request.
4. Obtained copies of compliance related policies and procedures, where needed, from Evolent, CountyCare's Third-Party Administrator (TPA) and the various delegated vendors providing services for CountyCare.
5. Reviewed, in conjunction with the TPA, twenty-four (24) policies addressing the following areas,
    - Fraud, Waste, Abuse, and Financial Misconduct;
    - Compliance Auditing and Monitoring;
    - Provider Audit and Recovery and Appeals Process;
    - Compliance Reporting and Non-Retaliation;
    - Exclusion Screening, License Verification, and Background Checks;
    - Conflict of Interest;
    - Delegated Entity Oversight/Monitoring;

[2] See 42 C.F.R. §438.608.

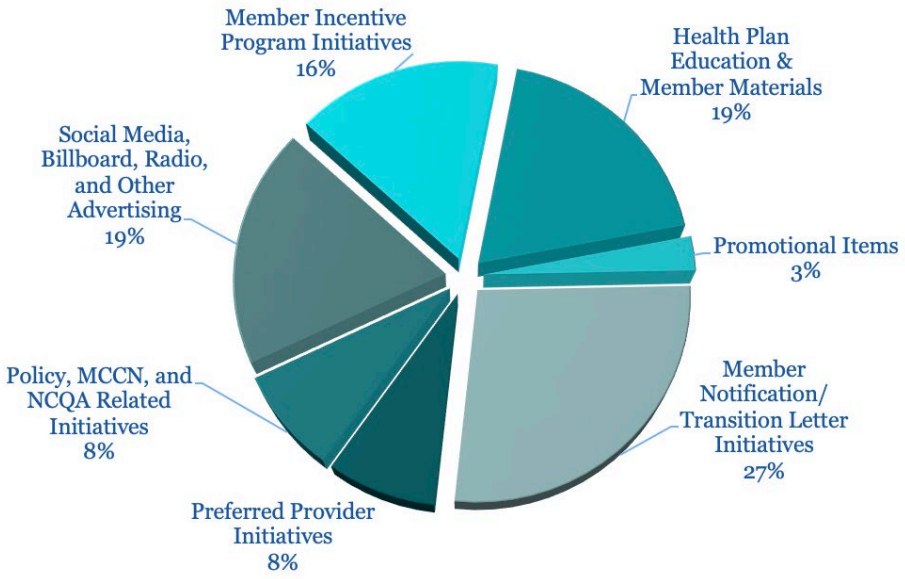
- Health Plan Marketing; and
- Subpoena Handling.

B. Ad Hoc Activities/Guidance

Corporate Compliance worked with operational areas to assess compliance with policies, procedures and/or regulatory requirements and, in certain instances, assisted in the development of new policies and procedures.

Examples of areas assessed:

- Health Plan Marketing Policy Compliance Review: Due to the ever-changing complex regulatory environment of Medicaid managed care plan marketing, Compliance reviewed and tracked all marketing materials before they were submitted to HFS for approval. In FY18, Compliance conducted 37 marketing and material reviews. 36 of 37 reviews conducted were approved by Compliance and subsequently, HFS. Each CountyCare initiative reviewed may contain multiple materials, however, each review is counted individually.



- Medical and Prior Authorization Policies: Worked with Evolent, CountyCare's TPA, to compile all medical payment and prior authorization policies and to identify areas of need.
- Authorized Representatives: Provided written guidance to the member call center regarding when they could speak with a member's representative based on a verbal consent.

- Abuse, Neglect, and Exploitation: Analyzed and provided guidance to CountyCare operations on the role as a mandated reporter of Critical Incidents and potential Abuse, Neglect, and Exploitation of members.
- New Prior Authorization and Utilization Management System: Partnered with the CountyCare Quality Department to ensure the upgraded method for communicating prior authorizations and delivering care management comports with accepted privacy and security standards.

Element 2

The designation of a Chief Compliance Officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who reports directly to the CEO and the governing body.

C. Compliance Office and Committees

Cathy Bodnar, the Chief Compliance and Privacy Officer, reports to both the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer. In turn, the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer each report to the CCH Board of Directors.

The CCH Compliance Officer responsible to assist the Chief Compliance and Privacy Officer in the operation of the CountyCare Compliance Program is Elizabeth Festa. The primary duties of the Compliance Officer assigned to CountyCare include the following:

- Serving in a leadership capacity to develop the CountyCare Compliance Program in conjunction with the Chief Compliance and Privacy Officer;
- Collaborating with CountyCare operational leadership to facilitate operational ownership of compliance;
- Overseeing the Plan's Program Integrity Program;
- Participating in CountyCare risk assessments to understand potential vulnerabilities;
- Establishing a structured process for regulatory review, monitoring, and dissemination of information related to Corporate Compliance;
- Periodically revising the Corporate Compliance Program Plan, with input from the Audit & Compliance Committee of the Board of Directors and Executive Management in light of changes directed to the needs of the health plan and the laws and policies of federal, state, and county bodies;
- Modifying policies, procedures, and projects to reflect changes in laws and regulations;
- Developing and coordinating compliance projects with CountyCare and delegated vendors;
- Performing interviews with all key personnel to validate compliance with established policies and procedures and applicable regulations in conjunction with other personnel, as deemed necessary;

- Completing ongoing assessments to evaluate potential strengths and weaknesses and to determine the adequacy of the overall CountyCare Corporate Compliance Program to ensure compliance, as deemed necessary;
- Providing guidance related to HIPAA and information sharing;
- Monitoring the health plan's Grievances and Appeals Program for patterns and trends while providing high level oversight;
- Providing recommendations to correct any potential weaknesses or areas of non-compliance discovered; and
- Performing follow-up reviews to ensure action plans have been adequately implemented.

The **Audit & Compliance Committee of the Board** advises the CCH Board of Directors regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management. The Audit & Compliance Committee of the Board receives periodic updates regarding the CountyCare Compliance program, including Fraud, Waste and Abuse (FWA) metrics and assessments of risk areas.

The **CountyCare Compliance Committee**, chaired by the Compliance Officer assigned to CountyCare, meets monthly and provides oversight of and guidance to CountyCare operations to ensure regulatory compliance and fulfill Compliance Program requirements, which include the implementation and operation of the Compliance Program. The Compliance Committee also reviews CountyCare activity pursuant to Compliance Program requirements and contractual requirements, including, but not limited to audits, monitoring activity, and corrective action plans. The Committee reports through the Chief Compliance and Privacy Officer to the Audit & Compliance Committee of the Board.

The **Fraud, Waste and Abuse Workgroup**, chaired by the CountyCare Compliance Officer with attendance by the Chief Compliance and Privacy Officer, transitioned from a monthly workgroup meeting to hoc committee convened to review the structure and effectiveness of the fraud, waste and abuse detection efforts.

The **CountyCare Executive Committee** is comprised of CCH senior delegates and CountyCare leadership and is responsible for providing oversight, guidance and support to CountyCare leadership to support the achievement of agreed upon goals in a manner consistent with a provider-sponsored organization. The Committee provides useful feedback to CountyCare leadership regarding Plan performance and promotes alignment between CCH objectives and CountyCare programs. The Committee meets once every two months.

The **HFS-OIG MCO Subcommittee** is comprised of HFS-OIG and Managed Care Organization's (MCO) compliance members involved in the program integrity functions of their respective MCOs. This subcommittee meets monthly to review and share

information regarding fraud, waste, and abuse activity as it relates to specific providers and trends.

Corporate Compliance **Program Integrity Meetings** with delegated vendors occur on a weekly, bi-weekly, and monthly cadence, depending on the vendor and amount of activity. Corporate Compliance oversees the vendors' activities and uses these meetings to approve, modify, or reject the direction of investigations and recoupment activity.

The **Delegated Vendor Oversight Committee** meets quarterly to provide oversight of the operations affecting the scope of functions of delegated vendors and subcontractors to ensure compliance with statutory and contractual requirements. The Committee also provides oversight of quarterly delegation audits, monthly joint operations meetings and regular monitoring of member and provider complaints. Identified areas of risk that fall under the purview of Corporate Compliance are referred to Corporate Compliance for assessment.

Element 3

The development and implementation of regular, effective education and training programs for all affected employees.

D. Education and Training

1. CountyCare – Provider MCCN Onboarding and New Employee/Contractor Orientation
    - Reviewed and updated provider onboarding orientation materials to fully incorporate corporate compliance requirements.

2. Targeted Education
    - Reviewed the MCCN Agreement for CountyCare training requirements and responsibilities and compared training materials submitted by the TPA and other delegated vendors to ensure compliance.
    - Provided regulatory summary regarding updates to 42 CFR Part 2 related to the disclosure of substance/alcohol abuse records.
    - Conducted a "HIPAA for Care Coordinators" and "HIPAA for Customer Service Members" targeted training for staff who work directly with members. Educated providers and care coordinators through guidance documents regarding HIPAA and information sharing for care coordination purposes. Created additional documents about HIPAA for care coordination staff who were part of the acquisition of FHN and Aetna membership.
    - Provided guidance to CountyCare employees regarding Power of Attorney documents and authority.

3. Annual CCH Compliance Education
    - Reviewed mandatory CCH training requirement to ensure that CCH trainings paralleled contractual and regulatory requirements for the health plan workforce. Identified need to include Critical Incident training for

CountyCare staff; reviewed classroom training content to validate contractual requirement was met.

Element 4

The maintenance of a process, such as a hot line, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

E. Effective Lines of Communication – Receiving and Responding to Complaints

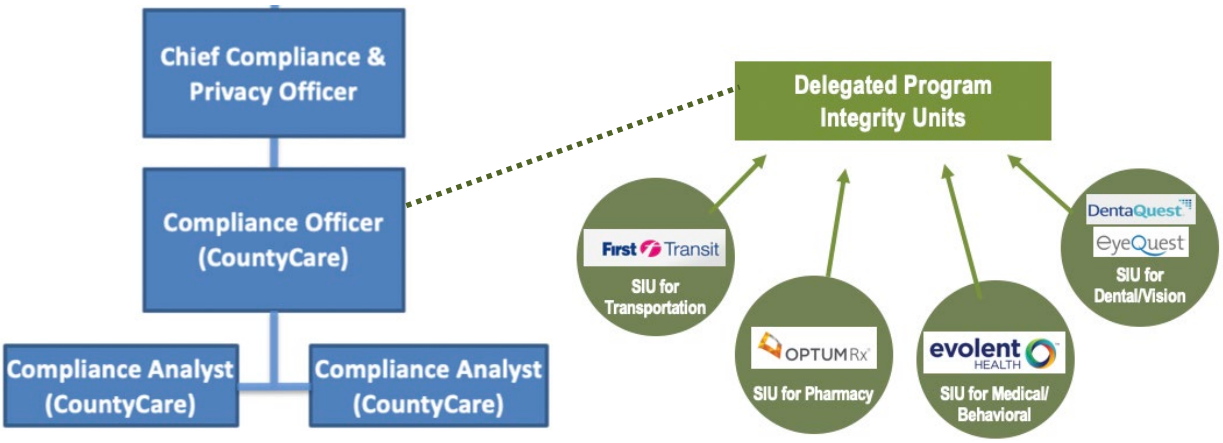
1. Infrastructure Activities
   - Monitored TPA's support and assistance to CountyCare members through the TPA's hotline service. Met weekly with TPA's compliance staff to discuss contacts received through the hot line and appropriate follow-up/responses.
   - Shared the accessibility of reporting concerns to the CountyCare workforce through:
     - A hotline service by a third party to preserve anonymity if desired;
     - A separate toll-free number for privacy breaches.
     - Open door policies of both the Compliance Officer assigned to CountyCare and the Chief Compliance and Privacy Officer;
     - Two (2) e-mail addresses for Compliance (compliance@cookcountyhhs.org) and Privacy (privacy@cookcountyhhs.org).
   - Established relationships and engaged internal and external resources to assist with investigations.
   - Identified trends and patterns to mitigate organizational risks and facilitate operational improvement.
   - Presented trends and patterns to the CountyCare Compliance Committee, CountyCare Executive Committee, Audit & Compliance Committee of the Board and the Managed Care Committee of the Board.

2. Process for Responding to Contacts and Complaints
   Maintained processes for contact, complaint management, and resolution as follows:
   - Investigated allegation;
   - Determined the area(s) affected;
   - Collaborated with operational leadership and appropriate entities;
   - Reviewed and followed contractual obligations, organizational policy, federal, state, and county regulations related to the incident for mitigation and remediation;
   - Determined and facilitated a resolution which may include a corrective action plan including education as needed; and
   - Responded to the complainant, as appropriate.

3. Reporting
   Categories have been defined to allow CountyCare Compliance to accurately measure general compliance contacts. The inclusion of a contact in a specific category does not substantiate the contacts as a concern; rather it classifies the contact within a defined category. The contacts addressed within the past fiscal year of CountyCare as a MCCN fell into the following categories:
   - Contractual Issues & Reviews
   - Regulatory/Policy Matters
   - HIPAA Privacy, Confidentiality and Security
   - Accurate Books & Records
   - Fraud, Waste and Abuse
   - Conflict of Interest
   - Other (e.g., subpoenas, unique grievance & appeals guidance, involuntary discharge of CountyCare member, etc.)

4. Fraud, Waste and Abuse
   Prevention, detection and elimination of fraud, waste, abuse, and financial misconduct is a key driver for CountyCare Compliance. Benefit and Program Integrity is critical not only because it a contractual requirement and a significant focus by the State and Federal government but because it is *the right thing to do*. The impetus of this key initiative is to ensure that federal, state, and county taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse in addition to protecting health plan members and providers.

   To identify potential fraud, waste, abuse, and financial misconduct, CountyCare Compliance partners with each delegated vendor through their dedicated areas commonly known as Special Investigation Units (SIU). The CountyCare Compliance Officer provides direct oversight of program integrity activity.



All Program Integrity activity is tracked by State Fiscal Year (S-FY) for state reporting purposes and not by county fiscal year. The S-FY runs from July 1st through June 30th.

FWA activity matters are raised through multiple modalities, to each delegated vendor or directly to Corporate Compliance. All allegations are tracked and monitored to resolution. In addition, other measures are undertaken through the SIUs. CountyCare utilizes data mining to identify providers with aberrant billing patterns and researches tips received from HFS, HFS-OIG, other Managed Care Organizations (MCOs), healthcare fraud groups, CountyCare employees, the media and other sources to identify overpayments.

Metrics for the S-FY18 follow:

Reporting Quarter	Tips	Preliminary Investigations	Full Investigations	Referrals to HFS-OIG	Audits	Overpayments Identified	Overpayments Collected
Q1 07/01 – 09/30/17	1	11	3	3	3	$ 97,910.84	$ 2,574.00
Q2 10/01 – 12/31/17	2	8	9	1	1	$ 201,038.64	$ 2,961.36
Q3 01/01 – 03/31/18 *	70	5	15	2	103	$ 457,245.29	$ 6,097.85
Q4 04/01 – 06/30/18	6	5	9	2	57	$ 2,305,959.74	$ 28,216.99

* The 3rd Quarter S-FY 18 was significant for CountyCare Compliance. Evolent, CountyCare's TPA for medical and behavioral health, hired two (2) local investigators dedicated solely to program integrity efforts. This dedicated team partnered with a data analytics firm to review claims for anomalies. The result of this activity is apparent in the metrics above.

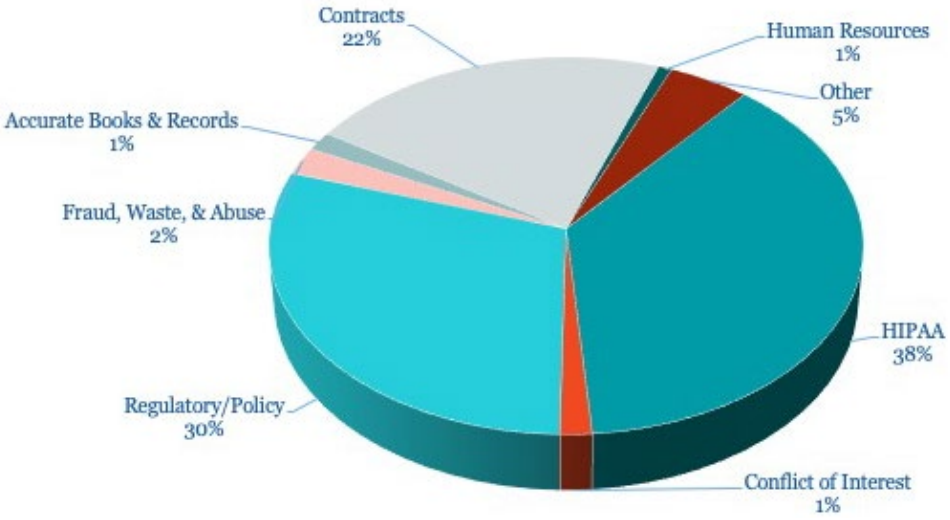
CountyCare Compliance monitored the process to ensure that appropriate action was taken, including reporting of suspected FWA to the State HFS-OIG.

In S-FY 2018, CountyCare referred 11 cases to the HFS-OIG for possible fraud, waste or financial misconduct.

5. Total Volume of General Compliance Contacts
In addition to the program integrity efforts above, a total of 125 general compliance contacts were tracked by CountyCare Compliance during the last fiscal year. This is a 29% decrease from last year. As noted earlier in this annual report, two (2) of the three (3) dedicated CountyCare Compliance Program positions were vacant.

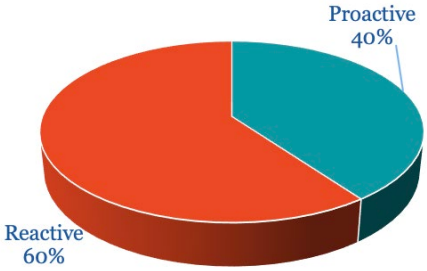
This placed a significant strain on the existing resources from March through August 2018. CountyCare Compliance had one full-time Compliance Analyst, Cory Otto. In the interim, Cathy Bodnar, functioned in an operational leadership capacity and with external resources providing supplemental assistance.

6. Contact Breakdown by Category (December 1, 2017-November 30, 2018)



Categories			
HIPAA (Privacy/Security)	47	Conflict of Interest	2
Regulatory/Policy	37	Accurate Books & Records	2
Contracts	27	Human Resources	1
Fraud Waste & Abuse	3	Other	6

With limited resources, CountyCare Compliance focused on contacts and issues that presented, shifting the balance from proactive to reactive or unanticipated queries or concerns. Of the 125 CountyCare contacts in FY 18, 40% or 50 contacts, were proactive. This was a significant decrease from the previous fiscal year, where 81% of the contacts were proactive activities that anticipated possible issues. The gradual return to a proactive paradigm is anticipated with the resolution of staffing issues.



7. HIPAA (Privacy and Security)
   As a covered entity, the health plan is required to safeguard privacy for plan members. Privacy and security of member information is highly regulated, and this category accounted for 47, or 38% of all contacts handled by compliance.

   During FY2018, CountyCare had fifteen (15) HIPAA incidents. None of the incidents required notifications to members. Twelve (12) of the fifteen (15) incidents were misdirected communications sent to another covered entity (another health plan, for example) or business associate (an entity doing business on behalf of the health plan).

8. Grievances and Appeals Activities
   The responsibility for Grievance and Appeals activity transitioned from Corporate Compliance to CountyCare Operations this fiscal year, specifically to leadership within Quality and Risk Management. CountyCare Compliance provides high-level oversight and remains committed to ensuring that contractual and regulatory timeframes are met, to providing guidance and assistance when necessary, and participating in the quarterly CountyCare Grievance and Appeals Committee.

Element 5

The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements.

F. Enforcing Standards

Broadened the scope of Standards enforcement through:

1. **Fraud, Waste and Abuse Monitoring.** As noted earlier in this report, CountyCare Compliance collaborated closely with the Special Investigation Units of Delegated Vendors to identify potential fraud, waste, abuse, and financial misconduct. Towards the end of the county fiscal year, Evolent, CountyCare's TPA for medical and behavioral health shifted to a second data analytics firm recognized for its expertise in DRG auditing and coding analysis.

2. **Privacy and Security (HIPAA) Breach Assessments.** As staffing for CountyCare Compliance stabilized, the area began to assume a greater responsibility for performing breach assessments. To maintain consistency in the approach, CountyCare Compliance partnered with CCH Provider Compliance to review allegations. If a privacy or security breach is validated, CountyCare Compliance provided remediation guidance to operational areas to minimize and/or eliminate breaches in the future and, utilized the CCH Sanction Policy and Personnel Rules, to provide leadership guidance for disciplinary action.

3. **Investigations Resulting in Employee Related Corrective Actions.** Investigated Conflict of Interest and confidentiality complaints and provided employee guidance.

4. **Partnerships with Governmental Agencies.** CountyCare Compliance partnered with the HFS, HFS-OIG, and Illinois' Medicaid Fraud Control Unit (MFCU).

5. **Partnerships with non-Governmental Agencies**. CountyCare Compliance was invited to participate with a number of new organizations related to the detection of fraud and wrongdoing in the insurance industry. These non-governmental organizations include the HealthCare Fraud Prevention Partnership (HFPP), National Insurance Crime Bureau (NICB), and Midwest Anti-Fraud Insurance Association (MAIA).

Element 6

The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.

G. Auditing and Monitoring

- Fraud, Waste, Abuse and Financial Misconduct
  As noted earlier in this report, CountyCare Compliance continued its partnership with SIUs, meeting regularly to build a robust system to identify potential financial misconduct, and formed partnerships with governmental and non-governmental agencies.
- Annual Compliance Attestation
  CountyCare Compliance continued to utilize an Annual Compliance Attestation, issued to all CountyCare's delegated vendors in April 2018. The Compliance Attestation required all vendors to attest to several compliance provisions in their contracts, including distribution of a Code of Ethics, FWA policy distribution, training and education requirements, sanction screening checks, and delegated oversight. All of the vendors responded, and one vendor required corrective measures.

H. Risk Assessment

The focus within CountyCare Compliance is prevention, detection and elimination of fraud, waste, abuse, and financial misconduct, however other areas of risk relating to member privacy and security of protected health information were identified in FY18. These also require ongoing assessment:

- Necessity for updated procedures to terminate employee access to 3rd party electronic systems upon separation from employment and to monitor current employee access.
- Disclosure and sharing of member sensitive health information.

In addition, CountyCare Compliance will initiate an annual risk assessment with executive leadership and key thought leaders nationally to identify outstanding risks and challenges to meeting the standards of an effective health plan compliance program.

Element 7

The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

I. Identification of Systemic Issues

- Sanction Screening Checks
  Addressed regulatory requirements to avoid employing, engaging, contracting or agreeing with any individual or entity that is excluded or "sanctioned" from participation in a federal or state health care program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services through ongoing monthly checks with an external vendor.

IV. Looking Ahead

In FY19 the Corporate Compliance Program will continue to focus on maintaining adherence to contractual requirements and healthcare compliance best practices as the program matures. As CountyCare relies heavily on delegated vendors, monitoring for adherence to CountyCare policies, contractual, and regulatory standards are critical to avoid sanctions. The Program will continue ongoing activities related to risk reduction in the areas of compliance, policy implementation, and the development and implementation of monitoring and auditing efforts.

These priorities have been established for the CountyCare Compliance Program:

- Strengthen health plan oversight in the area of fraud, waste and abuse,
  - Foster continued partnerships with HFS-OIG and the State's MFCU to develop best practices in Corporate Compliance for CountyCare.
  - Enhance relationships with non-government organizations and other MCOs' SIUs to build a network of skilled investigators and increase effective Program Integrity efforts.
- Continue to investigate all matters brought to the attention of the Program.
- Uphold compliance with contractual requirements and industry best practices as CountyCare continues as the largest Medicaid Managed Care Organization in Cook County.
- Foster partnerships with CountyCare Operations and delegated vendors to fulfill contractual obligations in Program Integrity and state reporting.
- Increase oversight and monitoring for all delegated vendors.
- Serve as a resource to the workforce and delegated vendors.
- Mature the CountyCare Compliance Program and continue to incorporate best practices to cultivate a culture of compliance throughout the health plan.
- Maintain CountyCare Compliance Program recognition locally and nationally.